DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

OMB Exempt

LONG-TERM CARE FACILITY APPLICATION FOR MEDICARE AND MEDICAID

Standard Survey:		**Extended Survey:**	
From: F1 *(mm/dd/yyyy)*	To: F2 *(mm/dd/yyyy)*	From: F3 *(mm/dd/yyyy)*	To: F4 *(mm/dd/yyyy)*

Name of Facility	Provider Number	Fiscal Year Ending: F5 *(mm/dd/yyyy)*

Street Address

City	County	State	Zip Code

Telephone Number: F6	State/County Code: F7	State/Region Code: F8

F9

01 Skilled Nursing Facility (SNF) - Medicare Participation
02 Nursing Facility (NF) - Medicaid Participation
03 SNF/NF - Medicare/Medicaid

Is this facility hospital based? F10 .... ○ Yes ○ No

If yes, indicate Hospital Provider Number: F11

Ownership: F12

For-Profit	**Non-Profit**	**Government**	
01 Individual	04 Church Related	07 State	10 City/County
02 Partnership	05 Nonprofit Corporation	08 County	11 Hospital District
03 Corporation	06 Other Nonprofit	09 City	12 Federal

Owned or leased by Multi-Facility Organization: F13 .... ○ Yes ○ No

Name of Multi-Facility Organization: F14

Dedicated Special Care Units: *(show number of beds for all that apply)*

F15 AIDS	F16 Alzheimer's Disease	F17 Dialysis
F18 Disabled Children/Young Adults	F19 Head Trauma	F20 Hospice
F21 Huntington's Disease	F22 Ventilator/Respiratory Care	F23 Other Specialized Rehabilitation

Does the facility currently have an organized residents' group? F24.................... ○ Yes ○ No

Does the facility currently have an organized group of family members of residents? .... ○ Yes ○ No

Does the facility conduct experimental research? F26 .... ○ Yes ○ No

Is the facility part of a continuing care retirement community (CCRC)? F27 .... ○ Yes ○ No

If the facility currently has a staffing waiver, indicate the type(s) of waiver(s) by writing in the date(s) of last approval. Indicate the number of hours waived for each type of waiver granted. If the facility does not have a waiver, write NA in the blanks.

Waiver of seven day RN requirement:		**Waiver of 24 hr licensed nursing requirement:**	
Date: F28 *(mm/dd/yyyy)*	Hours waived per week: F29	Date: F30 *(mm/dd/yyyy)*	Hours waived per week: F31

Does the facility currently have an approved Nurse Aide Training and Competency Evaluation Program? F32 .... ○ Yes ○ No

Name of Person Completing Form	Time
Signature	Date

GENERAL INSTRUCTIONS AND DEFINITIONS

(use with CMS-671 Long Term Care Facility Application for Medicare and Medicaid)

This form is to be completed by the Facility. For the purpose of this form "the facility" equals certified beds (i.e., Medicare and/or Medicaid certified beds).

Standard Survey: LEAVE BLANK – Survey team will complete.
Extended Survey: LEAVE BLANK – Survey team will complete.

INSTRUCTIONS AND DEFINITIONS

Name of Facility: Use the official name of the facility for business and mailing purposes. This includes components or units of a larger institution.

Provider Number: Leave blank on initial certifications. On all recertifications, insert the facility's assigned six-digit provider code.

Street Address: Street name and number refers to physical location, not mailing address, if two addresses differ.

City: Rural addresses should include the city of the nearest post office.

County: County refers to parish name in Louisiana and township name where appropriate in the New England States.

State: For U.S. possessions and trust territories, name is included in lieu of the State.

Zip Code: Zip Code refers to the "Zip-plus-four" code, if available, otherwise the standard Zip Code.

Telephone Number: Include the area code.

State/County Code: LEAVE BLANK. State Survey Office will complete.

State/Region Code: LEAVE BLANK. State Survey Office will complete.

Block F9: Enter either 01 (SNF), 02 (NF), or 03 (SNF/NF).

Block F10: If the facility is under administrative control of a hospital, check "yes," otherwise check "no."

Block F11: The hospital provider number is the hospital's assigned six-digit Medicare provider number.

Block F12: Identify the type of organization that controls and operates the facility. Enter the code as identified for that organization (e.g., for a for profit facility owned by an individual, enter 01 in the F12 block; a facility owned by a city government would be entered as 09 in the F12 block).

Definitions to determine ownership are:

For-Profit: If operated under private commercial ownership, indicate whether owned by individual, partnership, or corporation.

Non-Profit: If operated under voluntary or other nonprofit auspices, indicate whether church related, nonprofit corporation or other nonprofit.

Government: If operated by a governmental entity, indicate whether State, City, Hospital District, County, City/County, or Federal Government.

Block F13: Check "yes" if the facility is owned or leased by a multi-facility organization, otherwise check "no."

A Multi-Facility Organization is an organization that owns two or more long term care facilities. The owner may be an individual or a corporation. Leasing of facilities by corporate chains is included in this definition.

Block F14: If applicable, enter the name of the multi-facility organization. Use the name of the corporate ownership of the multi-facility organization (e.g., if the name of the facility is Soft Breezes Home and the name of the multi-facility organization that owns Soft Breezes is XYZ Enterprises, enter XYZ Enterprises).

Block F15 – F23: Enter the number of beds in the facility's Dedicated Special Care Units. These are units with a specific number of beds, identified and dedicated by the facility for residents with specific needs/diagnoses. They need not be certified or recognized by regulatory authorities. For example, a SNF admits a large number of residents with head injuries. They have set aside 8 beds on the north wing, staffed with specifically trained personnel. Show "8" in F19.

Block F24: Check "yes" if the facility currently has an organized residents' group, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to sup- port each other; to plan resident and family activities; to participate in educational activities or for any other purposes; otherwise check "no."

Block F25: Check "yes" if the facility currently has an organized group of family members of residents, i.e., a group(s) that meets regularly to discuss and offer suggestions about facility policies and procedures affecting residents' care, treatment, and quality of life; to support each other, to plan resident and family activities; to participate in educational activities or for any other purpose; otherwise check "no."

Block F26: Check "yes" if the facility conducts experimental research; otherwise check "no." Experimental research means using residents to develop and test clinical treatments, such as a new drug or therapy, that involves treatment and control groups. For example, a clinical trial of a new drug would be experimental research.

Block F27: Check "yes" if the facility is part of a continuing care retirement community (CCRC); otherwise check "no." A CCRC is any facility which operates under State regulation as a continuing care retirement community.

Blocks F28 – F31: If the facility has been granted a nurse staffing waiver by CMS or the State Agency in accordance with the provisions at 42CFR 483.35(e) or (f), enter the last approval date of the waiver(s) and report the number of hours being waived for each type of waiver approval.

Block F32: Check "yes" if the facility has a State approved Nurse Aide Training and Competency Evaluation Program; otherwise check "no."